IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9078

August 18, 2006

Carol Gonzales, Administrator
Burley Care Center
1729 Miller Avenue, P.O. Box 1224
Burley, ID 83318

Provider #: 135081

Dear Ms. Gonzales:

On **August 10, 2006**, a fire safety survey was conducted at Burley Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be a pattern of deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 31, 2006**. Failure to submit an acceptable PoC by **August 31, 2006**, may result in the imposition of civil monetary penalties by **September 20, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 14, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 14, 2006**. A change in the seriousness of the deficiencies on **September 14, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 14, 2006** includes the following:

Denial of payment for new admissions effective **November 10, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 10, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 10, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 31, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 31, 2006** process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135081	A. BUILDING 02 - ENTIRE BLDG B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLEY CARE CTR	PO BOX 1224 BURLEY, ID 83318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(000), fully sprinklered structure built in 1974 and is currently licensed for 68 SNF/NF beds. There are smoke detectors in corridors and open spaces. There is a basement that houses the laundry, maintenance shop , and offices. The facility completed a cosmetic project of floors and walls in 2001. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 10 August, 2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70. The Survey was conducted by: Chris Laumann, Health Facility Surveyor.	K 000		8-21-06

RECEIVED
AUG 31 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

M Gonzales — HSA Admin — 8-21-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation during a facility tour it was determined that the facility failed to ensure the proper closure and latching of corridor doors. 2 of 41 residents were effected. The finding included: 1. During a facility tour of the facility in the morning of August 10, 2006 at 10:30 AM, the door to room 6 was observed to not properly close and latch. Observation was witnessed by both surveyor and maintenance engineer.	K 018	1. Room 6 was unoccupied Latch replaced 8/10/06 2. Room inspection of all rooms and fire doors was completed 8/10/06, with staff in-serviced the same afternoon, to report such issues to Maintenance for immediate repair. 3. Door closure inspection is now a monthly monitor to be completed by maintenance engineer., to be immediately repaired. 4. To be reviewed monthly in CQI.	8-21-06

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K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation it was determined that the facility did not ensure that all exit access and corridors were provided with continuous emergency lighting. All staff members in basement were affected, which included maintenance engineer, 3 laundry room staff members, and any staff members on break in the basement break room. Findings included: Observation by surveyor and maintenance engineer on August 10, 2006, at 9:45 AM, disclosed that the emergency lighting within the stairway leading to basement, was inoperable.	K 046	1. The location of the exit access light in question was in an employee office area of the facility and is not a resident care area. Staff in-serviced 8/10/06. 2. All exit access and corridors were checked to insure they were provided continuous emergency lighting, 8/10/06. 3. A new battery was ordered 8/10/06 and was inserted upon its arrival to the facility. Exit lighting access and corridors are included as part of maintenance monthly inspection monitor. Staff in-serviced to be observant and to report such problems to Maintenance for immediate repair. 4. To be reviewed in CQI monthly. Also, an extra battery is now kept on hand.	8-21-06
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations during our facility tour it was determined that the facility failed to ensure compliance with electrical safety regulations. Two of 41 residents were in danger of electrocution and exposure to fire.	K 147		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 147	Continued From page 3 Findings include: 1. Observation on 10 August, 2006 at 10:27 AM, revealed a broken electrical outlet cover plate in room 5, exposing inhabitants to live wires. All finding were observed and noted by surveyor and maintenance supervisor.	K 147	1. Room unoccupied. Electrical cover replaced 8/10/06. 2. Room inspection of all rooms and room electrical outlet covers completed 8/10/06, with staff in-serviced the same afternoon, to be observant to such issues and to report to maintenance for immediate repair.. 3. Electrical outlet cover inspection is now integrated as a part of room inspection monitor, completed monthly by maintenance engineer. 4. To be reviewed monthly in CQI.	8-21-06

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, type V(000), fully sprinklered structure built in 1974 and is currently licensed for 68 SNF/NF beds. There are smoke detectors in corridors and open spaces. There is a basement that houses the laundry, maintenance shop , and offices. The facility completed a cosmetic project of floors and walls in 2001. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 10 August, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	C 000		
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: ;	C 230	RECEIVED AUG 31 2006 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Admin — (X6) DATE 8-21-06

Bureau of Facility Standards

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C 230	Continued From page 1 Refer to federal tags K 0018 which refers to corridor doors, K 0046 which refers to emergency lighting requirements, and K 0147 which refers to electrical code requirements. All federal K tags are documented on CMS-2567.	C 230	refer to K 18 refer to K 46 refer to K 147 as per phone Conversation on 12 Sept 2006 w/ Carol Gonzales. CDJ	8-21-06